2005 HIV PREVENTION GRANT APPLICATION

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I. COMMUNITY PLANNING

1) What specific actions has the health department taken to develop and implement a new Comprehensive HIV Prevention Plan in accordance with CDC's 2003 "HIV Prevention Community Planning Guidance?" What years will this plan cover?

The Idaho STD/AIDS Program and the Idaho HIV Care and Prevention Council developed a three year statewide 2004-2006 Comprehensive HIV Prevention Plan in 2003. This Plan was updated during the summer of 2004.

The STD/AIDS Program engaged in the following activities during January – June 2004 to meet the goals and objectives of community planning:

Maintained an active statewide community planning group - the Idaho HIV Care and Prevention Council (ICPC).

This 24-member group consists of persons living with HIV/AIDS, representatives of Idaho's priority population groups most at risk of infection, the STD/AIDS Program, HIV care and prevention service providers, and persons with expertise in behavioral science, evaluation, health planning, and education. Members serve three year terms, and new members are identified annually through an open recruitment process conducted by the ICPC Administrative Committee. The group meets three times per year.

Worked with the ICPC leadership to continually develop the structure, functioning, and capacity of the ICPC.

- The STD/AIDS Program conducted monthly conference calls with the ICPC Executive Committee. This committee consists of the ICPC Co-Chairs and Chairs of ICPC's five working committees (Administrative, Needs Assessment, Gap Analysis, Prevention Interventions, and Care Services). The monthly calls serve to coordinate and track community planning tasks, plan ICPC meeting agendas, and discuss ICPC capacity building.

- After a technical assistance presentation on conflict of interest at the November 2003 ICPC meeting, the STD/AIDS Program worked with an ICPC ad hoc committee to further develop ICPC's conflict of interest policies and procedures. This work resulted in an ICPC bylaws change which was approved at the June 2004 ICPC meeting.

- The STD/AIDS Program sponsored the attendance of three ICPC members at the June 2004 HIV Prevention Leadership Summit in Atlanta.

- The STD/AIDS Program and ICPC Co-Chairs conducted a new member orientation for ICPC members in January 2004. This training is done annually,

and is reinforced by new member mentoring from the Co-Chairs and Committee Chairs.

Convened two meetings of the ICPC. The ICPC met February 5-7 and June 3-5, 2004. Meetings were professionally facilitated, and the STD/AIDS Program supported all meeting and member travel costs.

Developed the epidemiologic profile and conducted the community service assessment.

The STD/AIDS Program –

- Provided the ICPC a full epi report at its June 2003 meeting, and assisted the group in using the data for planning decisions during subsequent meetings.

- Updated the Resource Inventory of Idaho's care and prevention services in early Spring 2004, and provided this information to the ICPC membership.

- Worked with the ICPC Needs Assessment Committee to conduct an assessment of MSM HIV prevention needs during early 2004. Draft results were provided to the ICPC Gap Analysis and Prevention Intervention Committees in early May, and a full report was reviewed with the ICPC at its June meeting.

- Supported the work of the ICPC Gap Analysis Committee as they met to conduct an analysis of MSM prevention gaps in Idaho. A draft report was presented to the ICPC in June 2004, with a final report produced in July.

- Supported the work of the ICPC Prevention Intervention committee as they researched potential MSM prevention interventions appropriate to implement in Idaho.

Provided other planning data to the ICPC.

The STD/AIDS Program, in partnership with the ICPC Executive Committee, planned a February 2004 ICPC meeting with an in-depth focus on effective HIV prevention with injection drug users (IDUs). Representatives from Idaho corrections and substance abuse services discussed potential partnerships for prevention activities. An Idaho State University School of Pharmacy faculty presented strategies for educating pharmacists and pharmacies on the importance of access to clean needle. An ICPC member representing the IDU population overviewed a potential peer outreach intervention. The Chair of the Prevention Intervention Committee reviewed CDC-recommended strategies for HIV prevention with IDUs.

In June 2004, the STD/AIDS Program reviewed CDC's Advancing HIV Prevention: New Strategies for a Changing Epidemic with the ICPC, and

discussed its impact on Idaho's prevention planning. The state also presented CDC's Diffusion of Effective Behavioral Interventions strategies.

Developed a 2005 Update to the 2004-2006 Comprehensive HIV Prevention Plan.

A 2005 Plan Update was drafted after the June 2004 ICPC meeting, and provided to the ICPC Executive Committee for review and concurrence in July. Plan updates included the latest ICPC membership profile, community planning timeline, 2004 Community Planning Membership Survey results, current HIV prevention activities for IDUs, and the most current community service assessment results. The ICPC recommended that no further changes be made to priority populations or interventions for 2005.

Awarded HIV prevention funds to carry out priorities identified in the Comprehensive Plan.

The STD/AIDS Program issued HIV prevention contracts in January 2004. Subcontractor workplans outlined the specific priority populations and interventions each entity would be conducting to carry out the priorities of the 2004-2006 Comprehensive Plan.

Provided updates to the ICPC on prevention activities being conducted in the state.

At the February 2004 ICPC meeting, the STD/AIDS Program presented how Idaho's 2004 federal HIV prevention funds had been allocated. Staff provided a handout that displayed the funding by category, and further broke out the contracted services portion by contractor, type of intervention funded, and priority population addressed.

At the June 2004 ICPC meeting, the STD/AIDS Program invited the agency that is implementing the statewide HIV testing media campaign to update the ICPC on campaign progress and impact.

Ensured collaboration.

Beginning in 2003, Idaho's HIV prevention community planning group incorporated the function of HIV care services planning as well. This has allowed for greater collaboration of efforts, especially with HIV prevention services to HIV+ persons, and early testing to identify infected persons and offer them care services. ICPC members receive updates on the state of Idaho's care services, and participate in the planning of care needs assessments.

The Idaho Department of Education discussed its HIV prevention efforts in Idaho's public schools at the February 2004 ICPC meeting. This served to better coordinate prevention resources in Idaho.

As noted previously, the Idaho Department of Corrections and substance abuse treatment providers had productive discussions with the ICPC in February on feasible ways to partner in HIV prevention efforts.

Evaluated the community planning process.

At its June 2004 meeting, ICPC members evaluated how well the group implements HIV prevention community planning. Members completed the CDC Community Planning Membership Survey, which addresses the performance indicators of community planning. Survey results were included in the 2005 Plan Update.

2) ***When will the annual update of your Comprehensive HIV Prevention Plan take place? What is your process for accomplishing this?***

Idaho's 2004-2006 Comprehensive Plan will be updated again during June – August 2005. Updates will be based on ICPC recommendations made during their January and June 2005 meetings.

In January, the ICPC will review and fine-tune the Plan's interventions for MSMs based on the planning information presented to them: epi data, MSM needs assessment results, a resource inventory, an MSM gap analysis, and an overview of potential MSM interventions.

In June 2005, the ICPC will make recommendations on interventions for the high risk heterosexual (HRH) population, following their review of epi data, a 2004-2005 assessment of high risk heterosexuals (HRH) prevention needs, an updated Resource Inventory, a gap analysis of HRH prevention needs, and recommendations for potential HRH interventions. This planning information will be sent to ICPC members well in advance of their June meeting.

3) ***What specific actions will take place between January and December 2005 to develop and/or implement the new plan? Please include discussion of the priority setting process*.**

The planning work of the ICPC discussed in #2 above will be accomplished through a facilitated, consensus-based decision making process. Proposed interventions will be evaluated by these factors: based on sound cognitive or behavioral theory, documented effectiveness, and appropriateness for Idaho's priority populations.

After the ICPC recommendations are incorporated in the 2006 Plan Update (during June-July 2005), the Plan will be provided to the ICPC Executive Committee for review, and the Co-Chairs will be asked to write letters of concurrence.

After the Plan Update is approved by the CDC, the STD/AIDS Program will determine how to best implement the plan's priorities. Request for proposals will need to be developed to identify qualified providers for interventions.

4) What specific activities will occur between January and December 2005 to address HIV-infected persons as the highest priority population in the jurisdiction?

- Idaho's epi profile on prevalence and incidence of persons living with HIV/AIDS, as well as risk factor contributing to infection, will be updated and provided to the ICPC.
- All needs assessment activities will incorporate assessing the prevention needs of persons living with HIV/AIDS.
- The ICPC Prevention Intervention Committee will research and recommend interventions for HIV+ persons. The committee's work will be directed by the outcomes of a November 2004 ICPC meeting that will have a full-day focus on effective prevention with this priority population in Idaho.
- The STD/AIDS Program will keep the ICPC informed of progress with current interventions for HIV positive persons in Idaho.
- The ICPC Administrative Committee will continue to ensure the active inclusion and representation of HIV+ persons on the ICPC.

5) What other activities will take place next year to enhance your community planning process?

- Committee Chairs will formally document each ICPC committee's tasks and processes, as well as the resources each committee needs to accomplish their work.
- The Administrative Committee will conduct an open recruitment process to fill any membership gaps in the ICPC.
- The STD/AIDS Program will sponsor the participation of 2-3 ICPC members at the 2005 HIV Prevention Leadership Summit.

6) Please discuss your plans for implementing community planning activities for calendar year 2005.

January 2005	Convene ICPC meeting. Conduct new member orientation. Make recommendations for 2004-2006 Plan updates on MSM interventions. Provide the ICPC with results of HRH needs assessment and Resource Inventory update.

	Report on how 2005 prevention funds have been allocated.
January – March 2005	Research potential interventions for HRH and send summaries to ICPC for review. Administer HIV+ needs assessment.
February – March 2005	Conduct gap analysis of HRH prevention services and send to ICPC membership.
March – August 2005	Identify ICPC membership gaps and recruit potential new members for 2006. Analyze data and write summary/report for HIV + needs assessment.
June 2005	Convene ICPC meeting. Make recommendations for 2004-2006 Plan updates on HRH interventions. Provide reports on outcomes of current prevention interventions. Evaluate the community planning process.
June – Dec. 2005	Plan and conduct needs assessment of IDUs.
June – August 2005	Update the 2004-2006 Comprehensive Plan, send to the ICPC for review, and obtain letters of concurrence. Write SCSN and Care Comprehensive Plan.
November 2005	Convene ICPC meeting.
Ongoing	Arrange technical assistance for the ICPC as needed / requested.
Ongoing	Provide support to the ICPC working committees.

II. COUNSELING, TESTING, AND REFERRAL SERVICES (CTR)

1) What specific actions took place between January and June 2004 to improve the provision of test results to persons who had received tests?

One of the contractor performance measures that is verified during site visits is their procedure for providing test results/post test counseling. All testing sites have a procedure in place. All test sites provide test results to positives in person and to highest risk negatives in person. For clients who are negative and at low risk, they are able to call the district health department for results or some of the district health

departments have a confidential envelope for them at the front desk. In the history of counseling and testing in Idaho all clients testing positive have received their test results through an in-person notification.

2) How are referrals for persons who test positive provided and tracked?

For persons testing positive in Idaho all are required in their contracts to refer to their local Ryan White II case manager. However, at this time there is not a method in place for tracking whether they actually went to the referred agency. The referral information that is gathered is housed in the Office of Epidemiology with the HIV Surveillance person. However, the current information is gathered on the CDC interview record which just asks, "Were they referred? Yes/No." It appears that the new HIV Counseling and Testing reporting form will include a page for referrals which we plan to use and implement when available. We anticipate this will allow us to track referrals through the HIV Counseling and Testing scanning software along with PEMS.

3) What actions will take place between January and December 2005 to further improve your return rate and ensure that appropriate referrals are provided and tracked?

It does appear that we may be able to better track this next year with the new CTS report form. If appropriate tracking tools are not provided for 2005 with the new CTS report forms and with PEMS then the Idaho STD/AIDS Program will work with the Ryan White II Coordinator and the HIV Surveillance Coordinator in determining if an in-house tracking system can be developed.

4) How many tests do you expect to be performed by the health department in calendar year 2005? What is your target return rate for all HIV tests performed by the health department?

We expect to perform 3,500 tests in 2005 with 50 percent of those having an identified high risk for HIV as identified by epi data. The target return rate will be 78 percent for all tests performed and 100 percent for all positives. The current return rate is 75 percent for all tests in 2003 and 100 percent for all testing positive.

5) Briefly describe your plan to implement rapid testing in your jurisdiction during calendar year 2005. How many grantees will provide rapid testing in 2005? What settings and venues will be included? How many persons do you expect to be tested? How will training on rapid testing be provided? How many rapid test kits will be needed to conduct rapid testing in the jurisdiction in 2005? How much money is needed to cover the cost of the test kits?

The Idaho STD/AIDS Program currently provides rapid testing and will continue to provide it as a testing option to contractors in 2005. Four grantees will provide rapid testing in 2005. The settings will include universities, juvenile detention, community based organizations, community gay pride events, homeless shelters, substance

abuse programs, and national testing day events. The plan will be to test 500 people using OraQuick test kits in 2005.
We will use our OraSure sales representative to provide an annual training and then request a training from CDC within the next two years. The estimated cost based on Orasure's current pricing scale would be:

500 kits	x $16.00 =	$8,000.00	(based on the projected oral OraQuick)
48 controls	x $20.00 =	960.00	(this cost will be covered by contractors)
Total		$8,960.00	

$8,000 would be needed to cover the test kits.

6) What specific steps will take place between January and December 2005 to support HIV screening in high prevalence settings, including emergency rooms?

Request will go out to all testing providers in September 2004 for proposals providing testing outside of the health district clinic to provide testing in high prevalence settings. Funds will be set aside to specifically fund these alternate test site locations to reach populations most at risk. Historically, these settings have included: drug rehabilitation centers, HIV/AIDS community-based organizations, detention centers, probation and parole, homeless shelters, juvenile detention, drug court, and other venues that reach at risk populations.

7) What other activities will take place next year to enhance your CTR program?

Revisions to our CTR program will be considered when CDC makes available the new data collection for the CTR database. The STD/AIDS Program will consider a fee for service for counseling and testing activities with the intent of generating an incentive to increase testing especially with identified at risk populations.

8) Please discuss your plans for implementing CTR activities for calendar year 2005.

In 2005, training will be provided to all CTR contractors regarding the new data collection tool for HIV testing and counseling.

All seven district health departments in Idaho will be funded to provide HIV Testing and Counseling within their geographic health district and encouraged to reach populations at risk which include; MSM/IDU, MSM, Heterosexual IDU, Sex Partner at Risk, Child of HIV Positive Mother, STD Diagnosis, and Sex for Drugs or Money. District health departments will also be offered additional funding for HIV testing provided outside of the district health departments with the goal of delivering services where the populations most at risk gather.

During 2005, the STD/AIDS Program will also analyze its counseling and testing data to determine whether a change in the target populations for testing services is warranted.

III. PARTNER COUNSELING AND REFERRAL SERVICES (PCRS)

1) How effective is your PCRS program in reaching partners of HIV-infected persons, ascertaining their HIV serostatus, and providing them with appropriate referrals? What barriers prevent you from being as effective as possible?

District health departments conducted 35 interviews of newly-reported HIV/AIDS cases in Idaho. Eighteen persons (51%) elected to do self-notification or did not participate in PCRS. Of the remaining interviewees, 28 partners were initiated, fourteen (50%) of which were given CTS. Eight tested negative, two were previous negatives who were counseled but refused testing, two were new positives, and two were previous positives. Of those who did not receive CTS, three refused CTS, seven were out of jurisdiction, and four were unable to be located.

Barriers to providing PCRS in Idaho include the non-cooperation of persons or partners of persons newly reported with HIV/AIDS due to a variety of factors and limited resources available for PCRS in some jurisdictions.

2) How many HIV-infected persons received health department provided PCRS between January and June 2004? On what data is this number based?

District health departments conducted 35 interviews of newly reported HIV/AIDS cases in Idaho. This number is based on data from investigations of newly reported HIV/AIDS cases, documented on CDC Field Record and Interview Record forms, and stored using the CDC data management software for STD investigations, STD*MIS.

3) Describe how the health department, your grantees, and STD clinics work together on partner notification and partner referral to CTR and other services.

Positive HIV cases from all providers are required to be reported to the district health department or the Idaho Department of Health and Welfare (IDHW) Office of Epidemiology and Food Protection (OEFP). Newly reported HIV or AIDS cases are required to be investigated by public health authorities under Idaho Administrative Code. District health departments are responsible for this investigation, which includes Partner Counseling and Referral Services (PCRS). Partners are referred to HIV counseling and testing services at the district health department and clients are given appropriate non-CTS referrals as needed as part of the PCRS process.

4) What specific actions will you take between January and December 2005 to strengthen your PCRS program and improve how PCRS is provided to HIV-infected clients in non-health department settings?

PCRS programs in district health departments will be strengthened through training and communication during calendar year 2005. The Idaho STD/AIDS Program coordinates PCRS training once each year, the training is provided by the California STD/HIV Prevention Training Center.

HIV PCRS is contracted to district health departments only in Idaho. Newly-reported HIV or AIDS cases are required to be investigated by public health authorities under Idaho Administrative Code. Aside from the legal responsibility, the advantages of district health department investigation (e.g., legal authority to review medical records, access to other records in commission of governmental duties) are valuable enough to maintain this exclusivity.

5) How many community-based agencies will provide PCRS activities and collaborate with the health department on partner notification? Briefly describe these agencies and how they will conduct PCRS.

HIV PCRS is contracted to health departments only in Idaho. Newly reported HIV or AIDS cases are required to be investigated by public health authorities under Idaho Administrative Code. Aside from the legal responsibility, the advantages of health department investigation (e.g., legal authority to review medical records, access to other records in commission of governmental duties, legal foundation for confidentiality) are valuable enough to maintain this exclusivity.

6) What other activities will take place between January and December 2005 to enhance PCRS in your jurisdiction?

Dependent on the CDC reporting requirements through PEMS and comparing those to the current variables collected on the CDC interview record, consideration will be given into reallocating funds from the HE/RR activities into PCRS.

The Office of Epidemiology and Food Protection conducts bimonthly conference calls with district personnel responsible for HIV PCRS. This includes any information on useful practices that OEFP relays in addition to a “Roundtable” discussion, where personnel help each other through difficult issues encountered through HIV PCRS or contact tracing for other STD. This sharing of experience and methods provides PCRS personnel with enhanced skills for providing effective PCRS.

7) Please discuss your plans for implementing PCRS activities for calendar year 2005.

District contracts for performing HIV PCRS – the OEFP-administered contract for General Epidemiology – are renewed annually each July.
PCRS Training – annually
Bimonthly conference calls

IV. PREVENTION FOR HIV-INFECTED PERSONS

1) Provide information on the current prevention programs/interventions for HIV-infected persons in the jurisdiction.

Intervention Name	Agency/Location	HIV-Infected Target Population	Target Race(s) and Ethnicity
Prevention Case Management HE/RR (GLI)	North Idaho AIDS Coalition/ Coeur d'Alene, Idaho	1—Female/Hetero 1—Male/MSM & IDU 1—Male/IDU 6-MSM (Primary) MSM/IDU (Secondary)	3—Non--Hispanic White 3 Non Hispanic Male 3 Non Hispanic Female
Prevention Case Management HE/RR (GLI)	North Central District Health Department	1—Male/MSM & IDU 1—Male/MSM 8-MSM (Primary) Heter (Secondary)	2—Non-Hispanic White 7 Non Hispanic Male 1 Non Hispanic Female
Prevention Case Management	South Central District Health Department	3—Male/MSM	3—Non-Hispanic White
Prevention Case Management	District 7 Health Department	1—Male/MSM 1—Male/Hetero	2—Non-Hispanic White

2) What additional program/interventions for persons living with HIV are planned for 2005?

Currently there are no additional programs planned for 2005.

3) Please describe the activities that took place between January and June to collaborate with health care providers and primary care clinics on the integration of HIV prevention into care and treatment services for HIV-infected persons.

The STD/AIDS Program initiated a statewide Prevention Case Management (PCM) Program in 2004 for HIV+ persons that are receiving case management services through Ryan White Title II and the Ryan White Title III clinics.

The intervention that was piloted in 2003 is currently structured to provide five sessions per client. The sessions include a HIV Prevention assessment that has been incorporated into the intake of all Ryan White Title II clients.

The initial assessment and how the client responded to questions regarding condom use, sharing needles, disclosing status, and responsibility in preventing the spread of HIV determines if they are referred into the PCM program. The program consists of an evaluation behavior change plan and risk assessment that focus on disclosure of status, condom use skills, injection drug use, and clients sense of responsibility in the spread of HIV. Pre and post data is collected for each individual in the program. The results will be reflected in the performance indicators.

PCM is a time limited behavioral intervention designed to assist HIV-seropositive persons who are having difficulty initiating and sustaining practices that limit the transmission of HIV. By focusing intensive prevention efforts on those who are at greatest risk for transmitting the virus, PCM holds promise as an effective prevention method. PCM is a more resource intensive intervention than other forms of client-level interventions such as group health education and risk reduction sessions or brief one-on-one counseling. The PCM intervention follows the components of CDC's HIV Prevention Case Management Guidance. In Idaho the development of a PCM program started in 2002 with a statewide PCM assessment of service capacity administered to all of the Ryan White Title II and III providers.

Findings from that assessment went into the development of the training and PCM pilot project in 2003.

4) Discuss the specific activities for collaboration among prevention, care, and treatment that are planned between January and December 2005.

The Prevention Case Management (PCM) project as described above will continue to be the activities collaborated between HIV Prevention, Ryan White Title II, and Ryan White Title III clinics.

5) What other activities will take place between January and December 2005 to expand or strengthen prevention with persons living with HIV in your jurisdiction?

A request for proposal (RFP) will be developed in 2005 for prevention interventions in the state of Idaho identifying prevention for HIV positives as a priority population. The RFP will be awarded in 2006 for prevention interventions reaching HIV positive people who engage in behaviors that risk transmitting HIV. Priority will be given to proposals submitted for interventions that are designed to reach HIV positive persons.

6) Please discuss your plans for implementing prevention activities for calendar year 2005 for HIV-infected persons.

Currently workplans have been provided to all contractors for 2005. The STD/AIDS Program has allocated funding for Prevention Case Management (PCM) to be provided to clients that are receiving Ryan White II care case management services. The PCM program is a five-session intervention that includes: harm reduction, safer sex/condom use, and disclosing their status to partners.

V. HEALTH EDUCATION AND RISK REDUCTION (HE/RR)

1) What steps have you taken under PA 04012 to ensure that your grantees provide interventions that are based on scientific theory, program theory, and/or evidence of effectiveness, including "DEBI" interventions?

Grantees applying for 2004 contract funds were required to submit an Executive Summary with their proposed interventions briefly explaining their program and interventions along with a rationale for how the intervention was chosen for their target population(s).

On each 2004 intervention workplan, grantees were required to indicate whether their interventions were evidence or theory based including a justification for the use of the theory.

Grantees were also required to submit a Session Content form for each GLI, ILI, and PCM intervention in order for the STD/AIDS Program to monitor the activities delivered during the intervention.

2) What steps did you take to require grantees to implement DEBI interventions or interventions from the Compendium?

We did not require grantees to implement DEBI interventions or interventions from the Compendium. However, one of our grantees uses a DEBI model and four others use modified versions of DEBI models. Also, we have encouraged our contractors to explore the implementation or continue to use interventions with evidence of effectiveness.

During the June 2004 statewide meeting of the Idaho Care and Prevention Council (ICPC), the Idaho STD/AIDS Program made a presentation on CDC's Advancing HIV Prevention: New Strategies for a Changing Epidemic. This presentation included a discussion of the DEBI interventions and dissemination of information regarding these interventions.

At a contractor's workplan workshop held in August 2004, contractors were given assistance on how to complete their workplans for 2005. A workplan template was developed by the STD/AIDS Program using the PEMS variables. At this workshop our contractors were given web addresses to resources for interventions and were made aware of the reasoning behind using interventions with evidence of effectiveness. Information provided by CDC through workshops, trainings, and conference calls involving the deployment of PEMS was used in developing the workshop agenda and workplan template.

3) Please describe how you will monitor grantees between January and December 2005 to ensure that interventions are based on theory or evidence of effectiveness.

2005 workplan proposals require grantees to indicate whether their interventions are based on a program model with evidence of effectiveness, CDC procedural guidance, or other basis for program model. Programs categorized as other basis for program model must address the theory or scientific rational for the model. Grantees are also required in their Executive Summary to include a justification for why their intervention is needed in their jurisdiction.

Grantees are required to submit curriculum with their workplan proposals for their interventions and to submit updates when program information is changed.

Grantees are monitored throughout the program year for adherence to activities outlined in their contract and workplans. This is done through process monitoring. Grantees may also be monitored for adherence to contracted activities through a site visit as these are conducted at least once every two years.

4) What interventions have been implemented?

The STD/AIDS Program contracted with 14 grantees to provide HE/RR interventions in 2004. Five of these grantees are local health departments and nine are community-based organizations.

Three grantees have implemented interventions targeting MSM in widely separate jurisdictions within the state. The intervention implemented in southeast Idaho is modeled on Mpowerment and is currently maintaining fidelity to the model and has received ongoing technical support from Center for AIDS Prevention Studies (CAPS). The STD/AIDS Program has received a letter from CAPS in support of how this model has been implemented in rural Idaho. There

is also an MSM intervention in Boise based on Empowerment theory and one in northern Idaho based on both the cognitive behavioral model and Trans-theoretical model.

Five grantees have implemented interventions targeting IDU. Three of these interventions have been implemented to incarcerated populations; one in Boise based on social learning theory, one in north central Idaho based on Social Empowerment theory, and one in southeast Idaho based on the Health Belief Model and Social Learning Theory. Two interventions targeting IDU are currently being delivered at substance abuse treatment centers; one in southwestern Idaho based on Orem's Self Care Model and one in eastern Idaho based on Social Learning Theory.

Six grantees have implemented interventions targeting high risk heterosexuals. Two of these interventions target youth; one in south central Idaho delivered to at-risk youth housed at Idaho Youth Ranch and based on Diffusion of Innovation Theory and one in north central Idaho delivered to American Indian at-risk youth based on the Street Smart Model. Three interventions target women at-risk; one in southeastern Idaho adapted from the Sista Model for rural Caucasian women, one in southeastern Idaho targeting African American women using the Sista model, and one in Boise targeting Caucasian women also adapted from the Sista model. One other intervention targeting heterosexuals was conducted in eastern Idaho and is an ILI based on the Transtheoretical model targeting partners of persons living with HIV.

Two interventions identified mother with/at risk for HIV as the target population. One of these interventions was implemented in Boise at a home for teen mothers based on several health belief models. The other was implemented in northern Idaho and is based on the Cognitive Behavioral and Transtheoretical Models.

See ATTACHMENT A for more specific information on each of these interventions.

5) If a grantee did not implement a DEBI intervention or an intervention from the Compendium, how will the intervention be monitored or evaluated?

All contractors including those who implement DEBI are monitored and evaluated in the same manner.

Site visits are scheduled at least once every two years. Contractors are required to complete a pre-visit monitoring form which is reviewed with the contractor at the time of the site visit. A letter is sent to the contractor following the visit that includes commendations, recommendations, and/or requirements with a time frame for corrective action if needed. Contractors must respond to the letter addressing recommendations and how they will meet requirements.

All interventions are monitored through submission of process monitoring forms. Intervention activities are reimbursed on a fee for service basis and require complete process monitoring documentation before services are reimbursed.

All HE/RR interventions with more than one session require outcome monitoring. Grantees submit outcome objectives with their proposals and measure outcomes for group-level and individual-level interventions throughout the program year. These outcomes are required for the purpose of program improvement and as a measure of the effectiveness of a specific intervention.

Contractors may use outcome monitoring tools developed specifically for their intervention (must be approved by the STD/AIDS Program) or they may use outcome monitoring tools developed by the STD/AIDS Program. Contractors who use the STD/AIDS developed outcome tools are required to submit completed questionnaires throughout the program year. All contractors must show evidence that outcome monitoring is taking place during site visits. An end of year program evaluation report is due to the STD/AIDS Program by December 1 of the contract year. The program evaluation report will include results of process evaluation and outcome monitoring.

6) ***For what interventions or intervention types do you and your grantees currently have written intervention protocols (e.g., PCM, GLI)?***

The STD/AIDS Program has written protocols for PCM.

Although the STD/AIDS Program does not have written protocols for interventions other than PCM, we plan to develop protocols for group and individual level interventions. The goal is to write and finalize these protocols for inclusion in an RFP for work beginning in 2006.

Currently, we do require grantees to submit an outline of session content for HE/RR interventions. Activities on the session content forms are spot checked against activities reported on process monitoring forms for validation of workplans.

7) ***Briefly discuss how you will monitor grantees next year to ensure the development and implementation of needed intervention protocols.***

As stated above, we plan to develop protocols for HE/RR interventions that fall under the “other basis for program model” during 2005 for implementation beginning in 2006.

8) ***What other activities will take place between January and December 2005 to strengthen HE/RR activities in the jurisdiction?***

The prevention intervention committee of the Idaho Care and Prevention Council (ICPC) will identify interventions with evidence of effectiveness that either were developed for implementation with high risk heterosexuals or can be adapted and tailored for use with high risk heterosexuals. They will present these interventions to the ICPC for consideration when developing the comprehensive community plan.

9) Please discuss your plans for implementing HE/RR activities for calendar year 2005.

We are in a continuation application process for 2005 workplan proposals. Grantees are required to submit workplan proposals for 2005 that include an executive summary briefly describing their programs and interventions including a rationale for the populations they are targeting, a budget summary and detailed workplans using an STD/AIDS Program template, any curriculum changes or updates, and a detailed evaluation plan for HE/RR interventions.

VI. PUBLIC INFORMATION PROGRAMS

1) *What types of public information programs were initiated in the jurisdiction since January 2004? Where, geographically, do these efforts take place and what are the target populations?*

The STD/AIDS Program initiated a statewide media campaign in 2003 to encourage people to "get tested" for HIV. The STD/AIDS program is committed to a three-year statewide media campaign. The campaign began with a random phone survey of over 400 individuals from across the state ages 18-39. This was followed by random focus groups using the same age group population since this is our target audience for HIV infection and testing. The research from these two activities indicated that Idahoans believe HIV/AIDS is a serious problem in our state and country. They are, however unaware that the State of Idaho has an HIV/AIDS program that has funding dedicated to education, prevention and treatment of HIV/AIDS. The goal of the media campaign is to shift the prevention responsibility from external (someone else) to personal response. Assessing personal risk for HIV and accessing testing services are a measurable outcome of this campaign.

The primary action we want from the public information campaign is to get our target audience to go to the Idaho HIV /AIDS website for information and then determine if they should be tested. The more inquiries and testing we generate, the more likely an unknown "positive" is discovered, and spreading the disease can be stopped. We also need to identify the "messenger" as Idaho STD/AIDS Program.

The advertising effectiveness was measured by tracking inquiries and testing to see if these numbers increase. The commercials regarding "Get Tested" started in November 2003. In January 2004, data was gathered from the number of website hits, calls to the state hotline (CareLine), number of tests administered at the health department, and a tracking survey. The results from these three assessments showed that in the fourth quarter of 2003 hits to the State STD/AIDS website increased 60 percent to the STD/AIDS homepage, 60 percent increase to the "get tested" link, 59 percent increase to the "where to get a test" link, a 58 percent increase in calls to the state hotline (CareLine) regarding

HIV/AIDS, and testing numbers at the district health departments increased by 58 percent in the fourth quarter with a 150 percent increase in positive test results (from two positive in 3rd quarter to five persons testing positive in 4th quarter).

In 2004, radio is the only media being used and will be run on a much more limited basis. One month over National Testing Day and one month prior to World AIDS Day. The data from the two years will be analyzed to determine the future direction of the campaign for 2005.

Along with the statewide public information campaign the STD/AIDS Program has also provided funding to each contractor to provide Health Communication/ Public Information and Outreach activities for World AIDS Day and National Testing Day.

2) ***What public information programs are planned for next year (include type of media, geographic areas, and target population)?***

Next year will be the final year of the planned three year media campaign. The previous two years have been on getting tested and in 2005, the focus will be on testing positive, targeting HIV positive persons. The campaign will be statewide. The Ryan White II program has also allocated funds for media for reaching the positive population. So, this will be a collaborated media project sponsored by HIV Prevention and Ryan White II.

Communications Objectives

Normalize the concept of individual testing to know your HIV status.

- Continue the use of mass media to encourage the target audience to get tested and know their HIV status.
- Continue with messages promoting personal responsibility for preventing the spread of HIV by knowing your status.
- Increase inquires about the program and testing information to the Idahohealth.org website and the Idaho CareLine (211).

Messages

Use existing research and conduct additional qualitative research to determine next phase message strategies promoting HIV/AIDS prevention.

- Test Viacom's tagline among Idaho adults: "Get Tested. You Can Live with the Results."

Building on personal responsibility, add a new message component offering prevention responsibilities and services available for those who have tested positive.
Continue call to action: 1) get tested and 2) for more information go to the website or call the CareLine.

Message Vehicles
Use paid mass media to deliver the broad, simple messages.
Use television (including cable) and radio to reach young adults statewide.

- Use creative messages to address specific target audience "hot buttons."
- Ability to build emotional message to connect with the audience.
- Electronic media provides non-profit benefit for public service messages.

Continue to use existing informational materials created for the target audience and health professionals. "Packaging" design allows for customization of information depending on the recipient.

Evaluation
Following this 3rd year of media efforts, evaluate the campaign with a follow-up tracking study that can be compared to previous baseline and tracking study.

-Measure efforts against the communication objectives.
-Plan future campaigns

VII. PERINATAL TRANSMISSION PREVENTION

1) What accomplishments occurred between January and June 2004 regarding work with health-care providers to promote universal HIV screening of pregnant patients?

Idaho's first case of HIV/AIDS was reported in 1985. Since then, 1,154 cases of HIV/AIDS have been reported. Of those reported, eight were through perinatal transmission. None of these eight cases were delivered in an Idaho health care facility. Six of the eight cases were born prior to 1995, when prophylactic treatment became the standard of practice.

With Idaho being a low prevalence state, the data for perinatal transmission does not warrant resources to target this population.

However, the STD/AIDS Program does think it's viable to collaborate with community partners in continuing to emphasize the message regarding the importance of pregnant women being tested for HIV. This was done through partnering with the local hospital and providing a booth on HIV education and perinatal transmission at the annual Perinatal Conference that is attended by over 250 health care providers specializing in Obstetrics, Gynecology, and Perinatal health care.

2) What specific activities will occur between January and December 2005 on collaboration with health care providers to promote HIV testing of pregnant women and prenatal and postnatal care for HIV-infected women?

The STD/AIDS Program through the NWAETC (Northwest AIDS Education and Training Center) will sponsor a doctor from the Idaho Ryan White Title III Clinic to present on HIV Testing of pregnant women and the care of HIV infected women at

the annual Idaho Perinatal conference which is held in February. The conference is attended by over 250 doctors, nurses, physician assistants in Idaho and sponsored by St. Luke's Regional Medical Center.

Also in 2005, The Maternal and Child Health (MCH) program will be sponsoring a statewide needs assessment focusing on identifying the priority health needs of the MCH population. This population includes pregnant women, infants, children, children with special health care needs and their families. They are looking at assessing the data the state currently has on the perinatal population as well as figuring out the gaps and how to get at the data we really need. We have requested that a question be added to the needs assessment regarding pregnant women being tested for HIV. This assessment involves the medical community including the Idaho Hospital Association, American College of Obstetrics and Gynecology (ACOG), American Association of Pediatrics (AAP), and Idaho Association of Family Practitioners (IAFP). Also included on the needs assessment advisory group are community groups such as the tribes, the migrant council, the Idaho Perinatal Project, and the local health district health departments.

VIII. QUALITY ASSURANCE

1) ***For what intervention or intervention types do you and your grantees currently have written quality assurance protocols (e.g., rapid testing, PCM, GLI)?***

In December 2004, the STD/AIDS Program offered an HIV rapid test training sponsored by the CDC to all current public health counseling and testing sites throughout Idaho. As part of that curriculum, participants were trained in the proper handling of blood-borne pathogens. After the completion of this training, Idaho participants were provided OraQuick test kits through a CDC program that provided free kits to the Idaho Department of Health & Welfare. There were three public health agencies that felt ready to offer this technology to its clients. OraQuick testing began in January 2004. Each agency was required to develop a quality assurance protocol prior to the initiation of OraQuick testing. Site visits and technical assistance was provided to each agency by the STD/AIDS Program's counseling and testing coordinator to help in monitoring the implementation and ongoing status of the testing program.

Prevention case management is a time-limited behavioral intervention designed to assist HIV- seropositive persons who are having difficulty initiating and sustaining practices that limit the transmission of HIV. During 2004, the HIV prevention project has partnered with Idaho's Ryan White Title II project to develop protocols and monitoring activities to assist in the delivery of quality HIV prevention interventions. The PCM consists of an evaluation, behavior change plan and risk assessment that focus on disclosure of status, condom use skills, injection drug use, and clients' sense of responsibility in the spread of HIV. Pre- and post-data is collected for each individual in the program. PCM activities are tracked through CAREWare, a software

management system utilized through the Ryan White Title II project. Chart review and intervention monitoring forms are also reviewed during contractor site visits conducted annually as part of the STD/AIDS Program quality assurance activities.

The STD/AIDS Program currently does not have quality assurance protocols for its funded HE/RR group- and individual-level interventions. However, plans are currently in the initial stages of development to develop protocols by 2005. These protocols will include standardized core components aimed at addressing the risks targeted by the intervention. The protocols may include risk reduction planning, risk assessment, condom negotiation, and negotiation of safer sex behaviors, condom use skills, risk-reduction strategies for injection drug users and referrals to counseling and testing. The protocols will also address client eligibility and collection of client level data.

2) ***In what ways will you work with your grantees between January and December 2005 to ensure the development and implementation of needed quality assurance protocols? How will you know that the protocols are being used and that agencies have a process for quality improvement?***

During 2005, the STD/AIDS Program will continue to conduct bi-annual site visits to monitor the quality of the HIV prevention interventions funded through this cooperative agreement. During monitoring activities, STD/AIDS Program staff verifies contractor adherence to all federal/state regulations and STD/AIDS Program's contract requirements. As stated above, the HIV Prevention Evaluation Specialist is in the process of developing HE/RR core components. Once these core components have been developed and approved, minimum standards will be determined and written into the 2005 contracts.

The STD/AIDS Program currently requires all contractors conducting HE/RR activities to conduct annual outcome monitoring activities. This requirement is a mechanism to encourage all contractors to utilize outcome monitoring as an instrument for quality improvement. Although the STD/AIDS Program has provided training to all of its contractors during each of the past two years, evaluation has been difficult to implement. This difficulty has been attributed to lack of capacity, limited resources and lack of intervention models available for rural, low prevalence states and on some contractors part an unwillingness to embrace program evaluation.

IX. MONITORING AND EVALUATION

1) Number of and position titles for health department FTEs devoted to data collection, data entry, data management, and analysis and reporting.

Position Title	FTEs devoted to data collection, data entry, data management, and analysis and reporting.
1 Program Evaluator	.7
2 Administrative Assistants	.5
1 Health Program Manager	.2
1 Health Program Specialist	.1

2) Plans for working with your grantees to meet the CDC monitoring and evaluation reporting requirements, including collection and submission of client-level data. Estimate the number of grantees within your jurisdiction who will be funded to deliver HIV prevention services, how you plan to train your providers on the new data collection requirements, and timelines for when your grantees will be collecting client-level data if they are not doing so currently.

Because we are in a continuation application process we expect to continue to fund the 14 grantees we are currently funded to provide HE/RR interventions and eight agencies to provide counseling and testing services.

Based on information received at PEMS data collection and deployment training, we plan to collect and report the following data during calendar year 2005 (see table below).

Data Type	Target Date for Data Collection	Data Collection Plan
Agency, Program Planning, & Community Planning Target Populations and Recommended Interventions	12/2004 for submission 4/2005	STD/AIDS Program staff will gather information on paper forms (included in the PEMS Implementation Planning Toolkit) and entered into PEMS. Data entry will begin at PEMS Release 1.0 training scheduled for October 25-29, 2004 Data will be submitted to CDC in April 2005.

Data Type	Target Date for Data Collection	Data Collection Plan
PCRS	3/2005 initiate pilot 65% collection required by 10/2005	Coordinate with OPEC procedure of PEMS data variables vs interview record variables. Determine who will manage the data.
CT	100% reporting required by 7/2005	The STD/AIDS Program is currently awaiting CDC deployment plan for recommended scanning software. Explore the purchase of recommended scanning software. Scan forms will be completed by grantees and submitted to STD/AIDS Program staff for scanning. Data will be submitted to CDC following PEMS submission guidelines each quarter.
PCM (HIV +)	100% of required data collection by 9/2005	Paper data collection forms currently being used will be checked for inclusion of required client-level data elements. Any required client-level data elements missing from currently used forms will be added. Client-level data is currently submitted to the STD/AIDS Ryan White II Program Specialist for entry into Careware. Role assignment for data entry of PCM client-level data into PEMS will be determined fall 2004.

Data Type	Target Date for Data Collection	Data Collection Plan
		Data gathered through submission of paper forms will be key entered into PEMS at the State HD level until grantees are trained on the use of PEMS software. Training of grantees to enter client-level data directly into PEMS will be scheduled during the second half of 2005.
DEBI, Other Procedural Guidance, Other HE/RR, Outreach, and HC/PI	Optional reporting in PEMS for low prevalence states	Even though reporting in PEMS is optional for this data we plan on submitting aggregate level data for these interventions based on the PEMS data variables for aggregate reporting. Confirm that current process monitoring forms collect the necessary PEMS data for each intervention type. Modify current process monitoring forms to collect aggregate data specified by PEMS. Grantees will complete and submit process monitoring forms at the time of billing. Data will be key entered by STD/AIDS Program staff into the PEMS system. Begin training grantees to directly enter data into PEMS in the second half of 2005.

3) ***Intended methods for data collection (e.g., paper and pencil, PDA) as well as methods for data entry into PEMS (e.g., key-entry, scanning, and file import). Include a description of how agencies will enter data into PEMS (e.g., each provider will have access to PEMS or other systems for data entry versus data will be entered only at and by the health department).***

Refer to table above under question 2.

4) ***Plans and procedures for assuring data security and confidentiality especially for your grantees/providers.***

Our prevention contract includes security and confidentiality clauses. We also monitor our grantees for written security and confidentiality policies during site visits.

We plan to include PEMS security policy measures in current STD/AIDS confidentiality policy once we receive more information from the CDC. It is understood that CDC will provide an MOU regarding security measures for use of PEMS software and grantees will have one year to implement these measures. CDC will also provide rules of behavior for end users of PEMS software.

5) ***For health departments that plan to use existing computer systems for PEMS, provide a plan and timeline for system modification to achieve compliance with PEMS requirements. System modification is dependent on CDC providing critical information on data variables, data relationship tables, and file format which may not be available in time to respond to this report. In the absence of this information, please include a general description of the work effort and lead time needed to revise your existing systems.***

We will use CPEMS. Our state health department computer system currently meets the requirements for CPEMS.

Most of our grantees meet the software requirements for CPEMS (currently 13 of the 14 grantees).

6) ***Status of progress against readiness checklists provided at the July 2004 Deployment Planning Workshops. Include discussion of tasks that are behind target.***

The Idaho STD/AIDS Program is currently on or ahead of task on the readiness checklists.

7) ***Anticipated challenges in meeting PEMS data submission requirements.***

At this point in time there are many unknowns in regards to how PEMS will function in the field. It is difficult to make some decisions in regard to level of data collection, given these unknowns.

We are awaiting a collection tool and scanning information for CT data variables. We have received very little information regarding how CT data will be managed in PEMS.

Client/intervention level data collection begins January 1, 2005. However, Release 2.0 of the PEMS system will not be ready for data entry until sometime in late winter/early spring 2005. The challenge will be developing user friendly paper forms to collect PEMS data variables from grantees so that data can be collected and later key entered into PEMS at the state health department. Even after grantees are trained to enter data directly into the PEMS system, paper forms will still be needed to gather some HE/RR performance indicators. We currently have paper process monitoring forms, some of which will need to be adapted to meet the data collection requirements of PEMS.

Even though it is optional for us to submit data for HE/RR, Outreach, and HC/PI into PEMS, we plan on using PEMS for monitoring of these interventions. We will key enter and submit at the very least aggregate data for these interventions through 2005. We anticipate getting a clearer picture of our grantees abilities to collect and report client-level data, once we have a better idea of how PEMS functions in the field.

Program Performance Indicators – *see ATTACHMENT B*

X. CAPACITY-BUILDING ACTIVITIES

1) ***What specific steps have you taken to implement a capacity-building needs assessment for the health department and health department grantees?***

   Unfortunately there has been no progress to date regarding the implementation of a capacity-building needs assessment. However, there are informal activities that have taken place to assess contractor's needs. These informal activities include an inclusion of the contractor quarterly reports requesting identification of any technical assistance in regard to program implementation and contractor training.

   A technical assistance request was made to the STD/AIDS Program's CDC project officer. This request included an example of an instrument and protocol used in another rural, low prevalence state. However, due to CDC's re-assignment of grantees for all project officers, this request was not fulfilled.

2) ***What capacity-building activities did you implement between January and June 2004? What capacity-building outcomes did you achieve?***

   The STD/AIDS Program provided an overview during 2004 of the CDC's Diffusion of Effective Behavioral Interventions (DEBI) models to the members of Idaho's Care & Prevention Council. As a result of this presentation, the

Prevention Intervention Committee is exploring in more detail those interventions that may be appropriate for Idaho. Consideration may be given to modifying interventions to better meet the need of Idaho's at-risk populations.

Also during 2004, the HIV prevention contractors were brought together to be introduced to the format for the 2005 contractor workplans. Prior to each contract period, each funded contractor is required to submit a plan to the STD/AIDS Program which defines the interventions to be performed, objective(s) for each intervention, and the monitoring strategies and instruments to be used to evaluate the interventions outcome.

3) What barriers did you experience in implementing your proposed capacity-building activities?

The STD/AIDS Program has seen a significant shift in program responsibilities and focus as a result of the upcoming implementation of the Program Evaluation Monitoring System (PEMS). Staff that would normally devote time and effort to capacity building activities has now been devoting more and more resources to PEMS. The STD/AIDS Program feels that it is being asked by CDC to add more to its project activities, but is not provided the resources to assist in meeting federal requirements. Consequently, the STD/AIDS Program must prioritize its focus and a structured capacity-building assessment has not been conducted.

4) What specific actions will take place between January and December 2005 to complete the needs assessment, implement a capacity-building plan, and conduct capacity-building activities?

This application serves as the STD/AIDS Program's formal request for technical assistance regarding the identification of a needs assessment instrument and sample of a capacity-building plan. Once this TA has been provided, the STD/AIDS Program will take appropriate steps to ensure that the state level program and its HIV prevention contractors capacity building needs will be assessed during 2005.

5) What technical capacity-building assistance do you need to carry out the actions described above in question #4?

Please refer to question #4 above.

XI. STD PREVENTION ACTIVITIES

1. What progress have you made in facilitating HIV counseling and testing in STD clinics?

Idaho has seven health district health departments that cover the state of Idaho. All district health departments have fully integrated HIV counseling and testing into their STD clinics. Some of the district health deparements still have additional clinic schedules specifically for HIV counseling and testing.

2. ***What specific activities will take place between January and December 2005 to further promote the coordination of STD screening, HIV counseling and testing, PCRS, and HIV prevention in STD clinics?***

   The Northwest AIDS Education Training Center (AETC) and the Seattle STD Training Center (PTC) will facilitate STD educational opportunities in 2004 and 2005 to those providing services under the STD/AIDS Program contract along with physicians, nurse practitioners, physician assistants, and other care providers.

   Currently several of the HIV prevention contractors in Idaho provide STD education as a component of their HIV prevention intervention. During 2005, a system will be developed to monitor how many clients receive STD education/prevention within HIV prevention interventions.

XII. COLLABORATION AND COORDINATION

1) **With which specific agencies has the health department collaborated since January 2004? Briefly describe the purpose and results of the collaboration.**

   Department of Education (DOE). The HIV Materials Review Committee is co-sponsored by the STD/AIDS Program and the DOE. The committee meets two times per year to review HIV-related materials in accordance with the CDC' guidance.

   Idaho Governor's Council on Adolescent Pregnancy Prevention (IGCAPP). The STD/AIDS Program is working with IGCAPP to coordinate and share media concepts for two separate media campaigns targeting adolescent pregnancy and STD prevention. This collaboration should result in a consistent and unduplicated message delivered to the target population, individuals 12-24 years of age.

   Office of Epidemiology and Food Protection (OEFP). Currently houses the surveillance activities for STDs and HIV reporting. Through the use of STD*MIS and HARS, the OEFP tracks partner notification activities. The OEFP is responsible for developing Idaho HIV/AIDS Epidemiological Profile for the STD/AIDS Program and Idaho Care & Prevention Council (ICPC).

   During a recent ICPC meeting the **Department of Corrections** and the DHW's **Substance Abuse Program** presented information on current HIV-related services provided to their clients/admittees. Information was also presented on risk factors their populations engage in that will help to determine their level of risk for HIV transmission. These presentations helped the community planning members better understand the services available and the way in which services are accessed.

Ryan White Title II/III Programs. The STD/AIDS Program oversees publicly-supported HIV and STD prevention and care services in Idaho. Many of the HIV prevention intervention contractors also provide HIV care services. During 2004, the HIV prevention and Ryan White Title II projects collaborate in the delivery of prevention case management services for HIV positive clients. Contractors currently providing Ryan White care case management are eligible to receive funding to expand services to include PCM activities.

Utah AIDS Foundation. The STD/AIDS Program was contacted by the Utah AIDS Foundation regarding our interest to partner with them on their application under CDC Program Announcement 04064. The services proposed included capacity building and the delivery of rapid testing services in rural parts of southeastern Idaho, northern Utah and southwestern Wyoming. Unfortunately, the application was not funded. However the collaboration between our two agencies continues with the Utah AIDS Foundation providing OraQuick testing services in the Southeastern Health Department region of the state. It has yet to be determined what role the Utah AIDS Foundation will play in Idaho's counseling and testing activities for 2005.

What tangible collaboration and coordination activities, including purposes and results, will take place between January and December 2005?

The STD/AIDS Program plans to continue its collaborative efforts identified in #1 above. In addition the STD/AIDS Program plans to:

- Partner with a number of agencies providing services to individuals at-risk for HIV transmission in 2005. This partnership will include the administration of a high-risk heterosexual HIV prevention needs assessment targeting the following types of agencies: counseling and testing clinics, substance abuse and treatment centers, homeless shelters, domestic violence/sexual assault shelters, Planned Parenthood of Idaho and university student health centers. The results of this needs assessment will be used by the Idaho Care and Prevention Council to identify and make recommendations to the STD/AIDS Program on effective interventions targeting this at-risk population.

- During 2005 the STD/AIDS Program plans to work with the Idaho Board of Pharmacy to develop a policy statement that supports needle exchange programs as an effective intervention to reduce the risk of HIV transmission for injection drug users.

- Ongoing collaboration with the Utah AIDS Foundation regarding the delivery of rapid test technology in southeastern Idaho will ensure the previously identified gaps in testing services will be filled.

XIII. MAJOR ISSUES DURING THE REPORTING PERIOD JANUARY-JUNE 2004

1) What HIV prevention activities posed the greatest challenges during the first six months of the project period?

Some of the challenges experienced the first half of 2004 were not having the new Counseling and Testing report forms (purple bubble forms) available from CDC. Using 1994 for 2004 in the date field and then having to do a conversion each time reports needed to be produced from the DOS CTS software program was cumbersome.

Two contractors targeting MSM reported barriers to implementing their interventions. Recruitment difficulties were reported by both contractors. The contractor in northern Idaho felt that MSM attending interventions were saturated with HIV prevention information and those attending sessions reported that they were not engaging in behaviors putting them at risk. The grantee is currently revamping his workplan and exploring serving other at risk populations in his jurisdiction.

The other MSM intervention located in Boise was not implemented due to the illness of the project coordinator and to reported problems with recruitment. The grantee for the Boise MSM project has proposed doing more formative evaluation activities for the second half of 2004 with the goal of implementing a workable MSM targeted intervention.

Finding contractors with the capacity to implement MSM interventions has been difficult. However, judging from the success of the Genesis Project in southeastern Idaho, it is possible to implement an MSM Program Model in rural Idaho.

All contractors conducting PCM interventions or prevention activities with positives have reported difficulties with recruiting or retention of clients to their interventions. Because providers asked for more training, a motivational interviewing course was offered for contractors providing these services.

Evaluation continues to be a challenge primarily in the area of outcome monitoring. We have been working with our contractors to develop outcome objectives that are based on the SMART model. We intend to see improvements in this area on the 2005 workplan proposals.

Several of our grantees continue to have some resistance to conducting outcome monitoring. Even though a standard outcome monitoring tool was made available to all contractors, those with resistance either failed to conduct outcome monitoring in the first half of 2004 or switched outcome monitoring tools. The largest complaint has been that they felt the tool they were using either was not appropriate for the target population or the clientele were already over surveyed. Developing reliable and valid outcome monitoring tools is challenging for a number of reasons. Although we have a standard tool it does not completely meet the needs of every program and population served.

During the first half of the year, the greatest challenge in preparing for the coming of PEMS has been dealing with the vast amount of variables, variable changes and trying to anticipate how collection of these variables will impact our grantees and how we administer and monitor our programs.

It appears that community planning apathy has set into the state of Idaho. Membership has decreased even though recruitment efforts have increased. A limited number of community planning members continue to produce the majority of work. Due to the loss of a chair for the Resource Inventory Committee, no other CP member was willing to step up and take a leadership role. Consequently, the gap was filled by staff of the STD/AIDS Program. Currently there are two vacant committee chair positions on the ICPC. During the February 2004 ICPC meeting, the chair of the Administrative Committee relinquished his leadership position due to burnout and to date a replacement has not been identified. In July, the chair of the Needs Assessment Committee accepted a job out of state and will be unable to fulfill his membership term.

New CDC program requirements continue to place a hardship on Idaho's limited resources. The PEMS ever changing timeline for its roll-out has caused much confusion at the state level. It is difficult to develop an implementation and training plan when it appears CDC is unclear of its expectations and reporting requirements.

2) What training, technical assistance, and/or capacity-building activities are needed to address these and anticipated issues during the next reporting period, January through December 2005?

We need to request that technical assistance/training be provided from CDC regarding the new CTS software and the capacity the program will have in generating reports.

The STD/AIDS HIV Program Evaluator would like training or technical assistance in the area of outcome monitoring and developing outcome monitoring tools.

Assistance in the following areas would also be welcome:

Technical assistance in developing basic protocols for HE/RR group- and individual-level interventions.

Capacity building to assist rural providers in adapting interventions with evidence of effectiveness for their populations.

Technical assistance in recruitment activities for rural or low-prevalence jurisdictions.

We need clear written language regarding what the data reporting requirements are for low prevalence states in regard to DEBI, Other Procedural Guidance, Other HE/RR, Outreach, and HC/PI. Even though we were told at Data Collection

Training that data collection in PEMS was optional in these areas for low prevalence states, we need to know what we are required to report for these interventions; especially what we are required to report in progress reports and grant application.

Clarification is needed from CDC on its plans to continue to support the community planning process. With CDC mandating target populations and strongly recommending the implementation of DEBI interventions, it appears the responsibility of the state's CP group is diminishing.

XIV. FUNDING AND STAFFING ISSUES

What funding, staffing, and/or issues are likely to affect the health department's ability to carry out the requirements of PA 04012 between January and December 2005?

During 2003-04, CDC provided Idaho 750 OraQuick test kits as part of its new initiative to expand counseling and testing services in the hopes of increasing the number of persons who know their HIV status. CDC would like to see states continue to offer this testing technology, but must now absorb the cost of the test kits into its already limited HIV prevention budget.

CDC is also introducing a new procedure for collecting and reporting HIV counseling and testing information. Funding to purchase a compatible scanner and software will also need to be absorbed with the level funding provided by CDC.

The STD/AIDS Program is anticipating a significant amount of staff time required to oversee the implementation of PEMS. The program is unable to increase FTEs to accommodate these programmatic changes due to a legislatively mandated number of positions approved for each state agency. Adding more tasks to the current staff responsibilities may result in a slower response time to our federal, state and local partners, inefficiency and increase error in reporting.

The apparent apathy within the state regarding HIV prevention appears to be an issue that will impact Idaho's ability to conduct community planning activities. Determining whether the apathy comes from the low prevalence within the state, lack of resources, asking people to volunteer has not been determined. But, this apathy has impacted prevention contractors' ability to identify and recruit target populations into HIV prevention interventions; ability to recruit new members to the Idaho Care & Prevention Council; and contractor burnout. HIV is no longer viewed as a debilitating disease eventually leading to death.

Another issue that may impact the STD/AIDS Program ability to carry out the requirements of PA 04012 is the limited availability of interventions targeting rural, low prevalence states. Although CDC is providing technical assistance to adapt existing models to rural, low prevalence states, these adaptations require state resources (personnel time & additional costs) to comply.

XV. CONCURRENCE OF HIV PREVENTION COMMUNITY PLANNING GROUP (CPG)

Letters of concurrence will be submitted prior to December 1, 2004.